Alabama Medicaid

Hospital Subpart Enrollment Application

Alabama Medicaid Basic Subpart Enrollment Information Form

Guidelines

- The subpart, for which you are using the Hospital Subpart Enrollment Application, must be a subpart of a hospital currently enrolled with Alabama Medicaid.
- Only hospitals enrolling subparts with a separate NPI than that assigned to the hospital are eligible to use this enrollment form.
- The effective date for all subparts enrolling utilizing this form will be **February 25, 2008**.
- If CLIA information is to be registered with Alabama Medicaid for the enrolling subpart, a copy of the CLIA certificate must accompany the enrollment form.
- If the banking information for the enrolling subpart is not to be the same as the existing hospital please call 1-888-223-3630, to request the appropriate Electronic Funds Transfer (EFT) form. The EFT form is to be completed and submitted with this enrollment form. Accompanying the EFT form must be a voided check or deposit slip to be used for verification purposes.

ALABAMA MEDICAID – HOSPITAL SUBPART ENROLLMENT APPLICATION

(1) The following information should be completed for the hospital:

Hospital's NPI Number:_____ **V**

Name: _____

Physical Address: _____ (City) _____ (State) _____ (Zip Cd +4) _____

(2) The following information should be completed for the subpart:

Type of Subpart (circle one): Rehab Psych

Subpart's NPI Number:_____

Subpart Name: _____

Physical Address: _____ (City) _____ (State) _____ (Zip Cd +4) _____

Mailing Address:_____ (City) _____ (State) _____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

County: _____ CLIA No _____ **V**

If CLIA information is to be registered with Alabama Medicaid for the enrolling subpart, a copy of the CLIA certificate must accompany the enrollment form.

(3) This information is to be completed for the hospital's subpart and will be used on your RAs and tax statements. This information must be consistent with the payee information provided to Medicare, the IRS and hospital NPI number indicated above.

Payee Name (to appear on RAs):_____ **V** IRS Tax No: _____ **V**

Payee Address: _____ (City)_____ (State)_____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Contact Person:_____ Phone Number of Contact Person:_____

NOTE: If the banking information for the enrolling subpart is not to be the same as the existing hospital please call 1-888-223-3630, to request the appropriate Electronic Funds Transfer (EFT) form. The EFT form is to be completed and submitted with this enrollment form. Accompanying the EFT form must be a voided check or deposit slip to be used for verification purposes.

I understand there may be state and federal penalties and prosecution for the making of false statements on this application. I certify that to the best of my knowledge, the information supplied on this application is accurate and complete and is hereby released to EDS for the purpose of enrolling in the Alabama Medicaid Program. By signing below I acknowledge this application is held to the same terms and conditions contained in the provider enrollment agreement signed during initial enrollment in the Alabama Medicaid Program.

_____ _____

Applicant's Signature (Must be personally handwritten) **Date**